

Note for the IPHU Health Systems

A Fact-sheetIntroducing Thailand and Thailand's Health Systems.

(Most of the text in this note is taken as such from Kingdom Of Thailand Health Systems Review 2015, part of the Health in Transition Series. If quoting from this note- please use original source)

Thailand has a population of about 70 million and a population density of about 130 persons per sq km.

Demography: Its sex ratio is 51.2% female and its rural population is 56.6% (latter are 2010 figures) Its birth rate is 12.1 and its total fertility rate is 1.6. More or less a stable population size. Those aged above 60 are about 9% and this is increasing.

Economy : Thailand's GDP per capita is 8120 in PPP and 4150 in dollars. Total Health Expenditure as proportion of GDP is 4.5% and of this 76% is the total public health expenditure (about 3.42%) . Public health expenditure is about 11% of its annual budget. (all public expenditure as part of GDP is 23%-to check)

Administration: Thailand is administratively organized into 76 provinces, 878 districts, and 7255 sub-districts (or tambons) and 74,944 villages (urban wards are additional to sub-districts and villages)

.Organization of health services (pg 116 to 119)

Primary Care- Understanding the CUP:

This is provided by an integrated network of the district hospital with the PHCs under it. Together they are called the Contracting Unit for Primary Care (or CUP) . Each district is a CUP- but there are others in urban units. The Public PHC which is part of this network is known as a Health Promoting Hospital (HPH). Most of the CUPs are district hospitals that are responsible for service provision in cooperation with a network of health centres or PHC unit within the district. Under the UCS, the first point of contact for a patient has been expected to be a local health centre or PHC unit; however, patients can directly access the hospital at which they are registered.

In 2010, there were 937 CUPs and 11 051 contracted PHC units in the public sector and 218 CUPs and 224 contracted PHC units in the private sector. The latter are mainly in the urban setting.

Hospital Services (pg 119)

The Ministry of Public Health (MOPH)owns the majority of hospitals in Thailand and this is a backbone of the Thai health system. MOPH hospitals have approximately 70% of all hospital beds and are distributed throughout the country, organized as a multilevel system outside Bangkok.

- District Level Hospital : There is a community hospital, with 30, 60, 90 or 120 beds, in all districts which covers a population of approximately 50 000.
- Provincial Level: At the provincial level, which covers a population of approximately 600 000, there is a general hospital with 150–500 beds.

- Regional Level : Some general hospitals have been upgraded to regional hospitals with 400–1000 beds and act as referral centres in the region.

In 2010, there were 730 district level community hospitals , 68 provincial hospitals and 25 regional hospitals, while the proportion of beds shared by each type was 46:31:23.

In general, the majority of community hospitals provide only basic medical care and inpatient services by general practitioners. However, community hospitals with 90 or 120 beds provide more complicated services by specialists in major areas such as internist, general surgeon, obstetrician and paediatrician.

General hospitals provide secondary to tertiary care and are the referral centre within the province.

Regional hospitals provide tertiary care and some of them have been upgraded to centres of excellence for particular services, e.g. cardiac, cancer and trauma.

Hospital services are also provided by some other ministries such as Ministry of Interior, Ministry of Defence, and Ministry of Justice. These were initially intended to provide services to their own specific populations; however, they are accessible to the public. Universities with a faculty of medicine also have teaching hospitals and act as referral

centres providing tertiary care. A few Provincial Administrative Offices and municipalities also have their own hospitals. In 2010, there were 7115 intensive care beds in 386 big hospitals, accounting for 5% of total beds. However, only 3% of MOPH hospital beds

Private hospitals

Almost all private hospitals in Thailand are private for profit and few of them are also on the stock market and target high-end populations and foreign patients. Private hospitals account for approximately 20% of total hospitals and beds and all of them are located in big cities, like Bangkok and its vicinity, and district capitals in the provinces. The number of private hospitals has declined slightly since 2003 (Table 5.1). Some private hospitals are registered as main contractors of public health insurance schemes UCS and SHI.

However, the numbers of private hospitals under these two schemes have been declining over time. In 2010, only 20% and 37% of private hospitals were main contractors of the UCS and SHI, respectively. Less attractive capitation rate paid by the schemes might explain the decline of number of private main contractors of these two schemes. Private hospitals under the public schemes are usually those of medium size, i.e. those with 100 beds or more, targeting lower- to middle-income populations. Moreover, the Civil Servant Medical Benefit Scheme (CSMBS) has been piloting a programme to allow CSMBS beneficiaries to obtain elective surgery in accredited private hospitals.

Table 5.1 Numbers of private hospitals providing services under different health insurance schemes, 2003–2010

	2003	2004	2005	2006	2007	2008	2009	2010
No. of private hospitals under UCS ^a	88	71	63	61	60	55	50	49
No. of private hospitals under SHI ^b	131	134	127	119	113	104	98	92
No. of private hospitals providing elective surgery for CSMBS ^c	–	–	–	–	–	–	–	26
Total no. of private hospitals ^d	260	260	259	258	253	256	255	250

Source: a National Health Security Office Annual Reports; b Social Security Office Annual Reports; c Comptroller General Department; d Annual reports of the Medical Registry Division, MOPH.

How is the Health Systems Financed?

Thailand has over 99% coverage with different financial protection schemes. This means for all of the population there is complete financial protection. They do not pay for any health care at the time of seeking it.

The main schemes are

- **Civil Servants Medical Benefits Scheme (CSMBS)** : Covers government employees and families. Roughly 6 million beneficiaries, Managed by ministry of finance
- **The Social Security Insurance Scheme: (SSI Scheme)**: Covers all organized workers and families. There is a contribution from the government and from the employer and the employee. It has roughly 9 million beneficiaries,. Managed by ministry of labour.
- **The Universal Coverage Schemes (UCS)** : Covers whoever is not covered by the above two schemes. Approximately 47 million beneficiaries. Managed by **National Health Security Organization (NHSO)** which is headed by the Minister for Public Health.
- Of the remaining 3 million about 2 million are migrants. Documented and undocumented- and both have schemes for them. UCS covers the stateless. There are very small others too.

How is the budget allocated to NHSO for UCS? (pg 70)

The size of the budget for UCS is negotiated annually between the NHSO and the Budget Bureau, and the final decision is made by the National Health Security Board, chaired by the Minister of Health. The budget is proposed on the estimated total expenditure per UCS member for that budget year, based on the previous year's utilization rate of outpatient and inpatient services, and projections for that budget year, and the cost per outpatient and inpatient, plus other components such as prevention and health promotion services. In the past, the budget has been increased significantly for service utilization and labour costs as a result of annual 6% government salary adjustments and inflation of other medical products.

Are there any user fees in UCS? (pg 72)

After the UCS launch in 2002, members were liable to copay a flat fee of 30 Baht (US\$ 0.7) per visit or admission; until in November 2008 the then new government abolished this copayment not only for political reasons, but also because some poor UCS members who were supposed to be exempted from copayment still had to pay due to poor exemption mechanisms. In 2012, the government reintroduced

30 Baht copayment for political reasons, but this was not practised in reality – it is socially unacceptable to UCS members. There are 21 groups of population who are exempted from copayment, and there is a group of persons who are not willing to pay. Hence, in practice there is no copayment. There have been some attempts to introduce copayment for medical care for UCS members who chose to stay in a private room, but the Council of State ruled this practice unlawful as it is against the National Health Security Act. Hospitals can only charge for the private room and board, but not for medical care. Also there is currently an attempt to introduce additional payment for medicines outside the national essential drug list (which is the available drug package under UCS, CSMBS and SHI) or brand-name products. This was discouraged by the government for fear of undermining the national essential drug policy and the lower-cost generic products, and the fear that it may result in two-tier systems, and loss of confidence by patients in the non-copayment systems. Arguments in favour of cost sharing to discourage moral hazard by beneficiaries has been counteracted by the fact that using close-ended payment methods to providers (e.g. capitation for outpatient and global budget plus DRG for admissions) sends a strong signal about cost containment and protects against effects of information asymmetry– it is very unlikely to see moral hazard by the patients, in particular when the patients have to trade-off with a period of waiting time.

How does UCS/NHSO make payment to district health system? (pg. 75) _

UCS estimates age-adjusted capitation for outpatient services to a contractor, typically a district health-care provider network (including a district hospital and 10–12 sub-district health centres serving a population of 50 000) based on the total number of members registered with the network. NHSO also sets a national global budget ceiling for admission services; based on electronic submission of every inpatient discharged from hospitals and the information on DRG, NHSO reimburses the total fund for admission services incurred to individual hospitals throughout the country on a monthly basis. There are also some other additional payments such as for high-cost services (e.g. bone marrow transplantation), for which a fee schedule is applied to certified providers. NHSO annual budget is a close-ended (or hard) budget, for which by the end of the year, budget for medical services will be fully disbursed to providers. It is not possible to carry forward to the next fiscal year or to overspend

How do patients access care?

Pg 115. 5.2 Patient pathways: Due to differences in system designs and access conditions of health insurance schemes, patient pathways differ between schemes. According to the capitation payment method adopted by the UCS, its members are automatically assigned to a local CUP. Most of the CUPs are district hospitals that are responsible for service provision in cooperation with a network of health centres or PHC unit within the district. Under the UCS, the first point of contact for a patient has been expected to be a local health centre or PHC unit; however, patients can directly access the hospital at which they are registered. Bypassing of PHC units by patients who directly access hospital outpatient departments (OPDs) has been decreasing. The ratio of patients accessing hospital-OPD/PHC unit was 1.2 in 2003 and 0.8 in 2011 (NHSO, 2011b).

How are the delivery of comprehensive services assured?

As the UCS applies the capitation contract model, beneficiaries are required to register with a preferred provider. UCS beneficiaries are required to register with the district health-care provider networks local to their residence. Due to geographical monopoly in rural areas, UCS beneficiaries have few choices. Normally, their provider network in their domicile districts is the MOPH district provider network (consists of district hospital and 10–15 health centres). For UCS members who reside in urban areas, there are choices of different public and private networks from which they are free to choose a network near their home. UCS members can

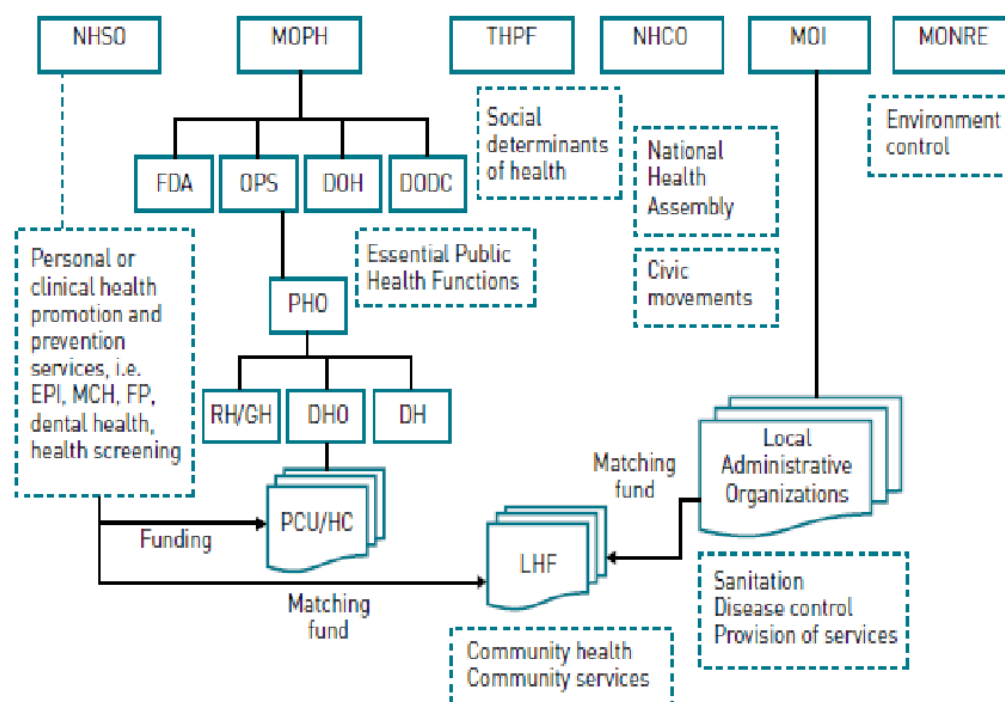
change their provider network twice a year. This is to facilitate the internal temporary migration. To achieve this, applicants need to prove that they reside in that area through one of the following proofs: (a) certification letter by house owner where they reside, (b) by the village head or other community leader, or (c) by electricity or pipedwater bills (showing their residency).

Beneficiaries are entitled to free services only from the registered provider network plus referral. Self-referral by patients is liable to full OOP payment. If the registered hospital cannot provide appropriate treatment, patients are transferred to a higher-level health-care facility such as a provincial or regional hospital, and sometimes a university hospital without any cost sharing; the transferring provider is responsible to pay for services rendered by higher level of outpatient care except admission services. This design is called fundholder primary care network.

All three public insurance schemes apply a negative-list concept, in which all services are included except those defined on the negative list. Included in the negative list are services without proven clinical effectiveness or that are nonessential such as cosmetic surgery.

What is the governance of public health services?

Figure 5.1 Organization of public health services in Thailand



NHSO: National Health Security Office; MOPH: Ministry of Public Health; THPF: Thai Health Promotion Foundation; NHCO: National Health Commission Office; MOI: Ministry of Interior; MONRE: Ministry of Natural Resources and Environment; FDA: Food and Drug Administration; OPS: Office of Permanent Secretary; DOH: Department of Health; DODC: Department of Disease Control; PHO: Provincial Health Office; DHO: District Health Office; RH/GH: Regional or General hospitals; DH: District hospital; PCU = primary health-care unit; HC: health centre; LHF: Local Health Fund; EPI: Expanded Programme for Immunization; MCH: maternal and child health; FP: family planning.

Source: Synthesis by the Author